

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3981ASC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/17/2014
NAME OF PROVIDER OR SUPPLIER ALTA ROSE SURGERY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 501 ROSE STREET, STE 110 LAS VEGAS, NV 89106		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of a State Relicensure Survey conducted in your facility from 04/16/2014 through 04/17/2014, in accordance with Nevada Administrative Code (NAC) Chapter 449, Surgical Centers for Ambulatory Patients.</p> <p>The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>The facility was found to be in substantial compliance. No further action is necessary with this survey. Please retain this statement of deficiencies for your records.</p>	A 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE